STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of Complaint Number IN00092713. Complaint Number IN00092713-Substantiated. Federal/state deficiencies related to the allegations are cited at F 226, F 279, F 282 and F 323. Survey dates: July 18, 19, 2011 Facility number: 000459 Provider number: 155567 Aim number: 100289700 Survey team: Ann Armey, RN Census bed type: SNF: 2 SNF/NF:72 Total: 74 Census payor type: Medicare: 16 Medicaid: 43 Other: 15 Total: 74 Sample: 3 These deficiencies reflect state finding cited in accordance with 410 IAC 16.2.	F0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 7/21/11 Cathy Emswiller RN			
F0226 SS=C	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to develop a policy stating all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility. This deficiency potentially affected all 74 residents residing in the facility. Findings include: The abuse policy, revised March 2011, provided by the Administrator, was reviewed on 7/19/11 at 9:15 a.m. with the Administrator. The policy indicated, among other things, that "... It is the responsibility of employees to promptly report to the facility Administrator any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors; including injuries of unknown source and theft or misappropriation of resident	F0226	It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. No residents were directly affected by the deficient practice. All residents had the potential to be affected by the deficient practice. The facility's Abuse Prevention, Intervention, Investigation and Reporting Policy have been revised to show that the administrator shall be notified immediately by employees of any suspected, instances, or allegations of abuse. All staff shall be inserviced on the change in policy terminology on 8/9/2011. QA&A Committee will monitor any allegations or instances of abuse for a period of 6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated to insure that the administror is notified immediately by employees.	08/17/2011

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	property. ...Additionally, the facility requires that employees promptly report the facts of known or suspected instances of abuse and all allegations of abuse to the facility Administrator (either directly or anonymously) so that facility's responsibility to protect residents and promptly investigate occurrences may be met. On 7/19/11 at 9:30 a.m., the Administrator was interviewed. He indicated the abuse policy had been recently updated. He indicated he felt the words "promptly" and "immediately" had the same definition and were equivalent. This Federal tag relates to Complaint #IN00092713. 3.1-28(a)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interviews and record review, the facility failed to develop, and revise care plans to prevent falls. This deficiency affected 2 of 3 residents with multiple falls in a sample of 3. (Resident #B, and #C) Findings include: The closed clinical record of Resident #B was reviewed on 7/18/11 at 2:00 p.m., and indicated the resident was admitted to the facility from the hospital on 5/16/11, with diagnoses which included but were not limited to, dementia and CVA (Cerebral Vascular Accident). Resident #B was discharged to an assisted living facility on	F0279	It is the facility's policy to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Resident B was discharged from facility on 6/21/11, unable to address. Resident C falls careplan was reviewed on 7/29/11 by IDT to ensure appropriate and progressive interventions have been put in place to minimize falls. Other residents with multiple falls in previous 3 months shall be reviewed by IDT to ensure appropriate progressive interventions have been put in place to minimize falls. Licensed Nursing staff and IDT to be reeducated on facility's fall management program policy and procedure. DON or designee will review all falls and interventions to	08/17/2011

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	6/21/11. The fall risk assessment, dated 5/16/11, indicated Resident #B was at high risk for falls. The fall risk care plan, dated 5/16/11, indicated Resident #B had fall risk factors, including; CVA, dementia, weakness and history of falls. The fall prevention interventions included: Provide adequate lighting Monitor side effects of meds (medications) Keep call light within reach Encourage use of call light Keep floors free of spills and clutter Monitor for unsteady gait and balance Labs as ordered Assess toileting needs Provide verbal safety cues Keep personal belongings within reach Keep assistive devices within easy reach (Wheel Chair) Wear clean & (and) clear eye wear Provide non-skid foot wear PT eval (physical therapy evaluation) and treat if indicated OT eval (occupational therapy evaluation) and treat if indicated Pressure sensor pad in bed (and) w/c (wheelchair) Low bed		ensure that the most appropriate measures have been put in place to minimize the risk of falls for the resident. QA&A will monitor residents with multiple falls monthly to ensure the effectiveness of the staff utilization of the falls management program for a period of 6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	

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	Physician orders, dated 5/16/11 and 5/17/11 respectively, indicated Resident #B was to have a PSA (Pressure Sensor Alarm) on the bed/ wheelchair at all times and was to receive Physical/Occupational Therapy five times per week for eight weeks. MDS (Minimum Data Set) Assessment, dated 5/23/11, indicated Resident #B required extensive assistance for transfer and toileting. The BIMS (Brief Interview of Mental Status) scores on the MDS assessments, dated 5/23/11, 5/26/11, and 6/7/11, indicated Resident #B had severe cognitive impairment. Resident #B sustained three unwitnessed falls on 5/19/11, 5/20/11 and 6/4/11; as follows: On 5/19/11 at 5:50 p.m., A fall investigation form indicated resident #B fell from her wheelchair. According to the report, a CNA heard the PSA (Pressure Sensor Alarm) sounding and found the resident on the floor sitting in front of her wheelchair. The Resident "was educated 0 (not) to lean forward to get objects out of reach, to use call light to ask for assistance..." The report indicated Resident #B complained of right hip pain, an x-ray of the right hip was ordered and neuro checks were			

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	initiated. On 5/20/11 at 8:00 a.m., Resident #B sustained a second fall. A change of condition report, dated 5/20/11, indicated Resident #B was observed sitting on the bathroom floor, the alarm had been removed, and the resident had attempted to self transfer to the toilet. The post-fall care plan indicated "encouraged use of call light for assistance." CNA #1, who discovered the resident on the floor, was interviewed on 7/19/11 at 12:00 noon, and indicated the resident's alarm was not sounding, when she discovered the resident on the bathroom floor. She indicated the resident had shut off her alarm. The right hip x-ray report, dated 5/20/11, noted an irregularity and bony fragment at the greater trochanter. Nursing notes, date 5/21/11 at 7:50 a.m., indicated physician orders were obtained to transfer the resident to the emergency room for evaluation of the right hip. The hospital emergency report, date 5/21/11 at 1:12 p.m., indicated Resident #B was returned to the facility following an examination and a normal MRI (Magnetic Resonance Imaging) of the			

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	right hip. On 6/5/11 at 3:30 p.m., Resident #B sustained a third fall. The fall investigation report indicated the alarm was sounding and Resident #B was found on the floor next to her bed. According to the report, she had attempted to transfer from the wheelchair to the bed without assistance and missed the bed. The report indicated the "resident was reeducated on use of call light." The alarms, therapy and non-skid socks, previously care planned, were continued. The care plan indicated the only new fall prevention intervention attempted for the cognitively impaired resident, following the falls, was re-education and encouragement to use the call light. There was no documentation the use of the PSA alarm was reviewed or that the need for additional supervision was considered or planned. On 7/19/11 at 12:10 p.m., the Administrator was interviewed regarding Resident #B's falls. He indicated re-education of a dementia resident was not an appropriate intervention. He indicated more "tangible" interventions should have been implemented to prevent her falls.			

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	2. On 7/18/11 at 9:30 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #C had multiple falls. On 7/18/11 at 10:00 a.m., Resident #C was observed sitting in her wheelchair, in the therapy room, with an alarm attached to her clothing. On 7/18/11 at 1:30 p.m., she was observed resting in bed with an alarm attached to her clothing. The bed was in a low position. The clinical record of Resident #C was reviewed on 7/18/11 at 3:20 p.m., , and indicated the resident was re-admitted to the facility on 2/20/11 with diagnoses which included but were not limited to, left hip arthroplasty and Alzheimer's dementia. The MDS (Minimum Data Set) assessment, dated 4/21/11, indicated the resident required extensive assistance for transfer and toileting The most current fall risk assessment, dated 7/8/11, indicated the resident was at high risk for falls.			

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	The resident had four recent falls on 6/11/11, 6/25/11, 7/4/11 and 7/14/11, as follows: On 6/11/11 at 9:30 a.m., a fall investigation report indicated Resident #C was found on the activity room floor between the wheelchair and the couch. The report indicated Resident #C was found to have a purple discoloration on her lower back measuring 5 CM by 0.2 CM. Neuro checks were initiated for 72 hours The post-fall and the fall risk care plan indicated the interventions initiated, after the 6/11/11 fall, included; a pull tab alarm when up in wheelchair, assist to comfortable position in wheelchair, attempt to identify reasons for restlessness and address, increase frequency of activity program, and provide visual checks on a scheduled basis. On 6/25/11 at 12:05 p.m., Resident #C sustained a second fall. A change of condition report indicated Resident #C was found on the living room floor between the wheelchair and couch, the alarm was sounding, the resident was assisted to bed, neuro checks were initiated for seventy two hours and a 3 cm			

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	by 2 cm discoloration was noted on her right knee. The interventions initiated on the fall risk and the post fall care plan, after the 6/25/11 fall, indicated hospice was to evaluate wheelchair positioning, and was to provide a low bed with floor mat. On 7/4/11 at 8:45 a.m. Resident #C sustained a third fall. A change of condition report indicated the alarm was sounding and Resident #C was found on the floor, after she attempted a self transfer from the wheelchair to the love seat in the activity room. The care plan intervention, following the 7/4/11 fall, indicated the resident was to be referred to therapy. On 7/14/11 at 6:55 a.m. Resident #C sustained a fourth fall. A change of condition report indicated Resident #C was found on the floor between the bed and the door. The report indicated the alarm did not sound and the resident had thrown the alarm across the room. The report noted no physical injuries. The interventions added to the fall risk care plan, following the 7/14/11 fall, indicated the alarm was put back in place. There was no documentation the			

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	effectiveness of the alarm, the response to the alarm or the positioning of the alarm had been reviewed. There was no documentation additional supervision of the resident was planned. The policy for Falls Management, dated October 2010, provided by the Administrator, was reviewed on 7/19/11 at 1:30 p.m. and indicated, "...2. Initiate a fall prevention care plan when appropriate with strategies to minimize falls and injuries. 3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries... 7. Evaluate actual or suspected causal factors for opportunities to prevent recurrences..." The policy included a page of clinical options and strategies for the management of fall risks. This Federal tag relates to Complaint Number IN00092713. 3.1-35(d)(2)(B)			

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interviews and record review, the facility failed to implement care plans to prevent falls. This deficiency affected 1 of 3 residents with multiple falls in a sample of 3. (Resident #C) Findings include: 1. On 7/18/11 at 9:30 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #C had multiple falls. On 7/18/11 at 10:00 a.m., Resident #C was observed sitting in her wheelchair, in the therapy room, with an alarm attached to her clothing. On 7/18/11 at 1:30 p.m., she was observed resting in bed with an alarm attached to her clothing. The bed was in a low position. The clinical record of Resident #C was reviewed on 7/18/11 at 3:20 p.m., , and indicated the resident was re-admitted to the facility on 2/20/11 with diagnoses which included but were not limited to, left hip arthroplasty and Alzheimer's dementia. The MDS (Minimum Data Set)	F0282	It is the facility's policy that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Resident C falls careplan was reviewed on 7/29/11 by IDT to ensure appropriate and progressive interventions have been put in place to minimize falls. Other residents with multiple falls in previous 3 months shall be reviewed by IDT to ensure appropriate progressive interventions have been put in place to minimize falls. Licensed Nursing staff and IDT to be reeducated on facility's fall management program policy and procedure. DON or designee will review all falls and interventions to ensure that the most appropriate measures have been put in place to minimize the risk of falls for the resident. QA&A will monitor residents with multiple falls monthly to ensure the effectiveness of the staff utilization of the falls management program for a period of 6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	08/17/2011

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	assessment, dated 4/21/11, indicated the resident required extensive assistance for transfer and toileting The most current fall risk assessment, dated 7/8/11, indicated the resident was at high risk for falls. The resident had four recent falls on 6/11/11, 6/25/11, 7/4/11 and 7/14/11, as follows: On 6/11/11 at 9:30 a.m., a fall investigation report indicated Resident #C was found on the activity room floor between the wheelchair and the couch. The report indicated Resident #C was found to have a purple discoloration on her lower back measuring 5 CM by 0.2 CM. Neuro checks were initiated for 72 hours The post-fall and the fall risk care plan indicated the interventions initiated, after the 6/11/11 fall, included; a pull tab alarm when up in wheelchair, assist to comfortable position in wheelchair, attempt to identify reasons for restlessness and address, increase frequency of activity program, and provide visual checks on a scheduled basis. After the neuro checks were completed,			

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	there was no documentation visual checks of Resident #C were provided on a scheduled basis. On 7/19/11 at 12:10 p.m., the Administrator was interviewed. The Administrator indicated, after the neuro checks, he could find no documentation visual checks were done on a scheduled basis. On 6/25/11 at 12:05 p.m., Resident #C sustained a second fall. A change of condition report indicated Resident #C was found on the living room floor between the wheelchair and couch, the alarm was sounding, the resident was assisted to bed, neuro checks were initiated for seventy two hours and a 3 cm by 2 cm discoloration was noted on her right knee. The interventions initiated on the fall risk and the post fall care plan, after the 6/25/11 fall, indicated hospice was to evaluate wheelchair positioning, and was to provide a low bed with floor mat. On 7/4/11 at 8:45 a.m. Resident #C sustained a third fall. A change of condition report indicated the alarm was sounding and Resident #C was found on the floor, after she attempted a self			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfer from the wheelchair to the love seat in the activity room. The care plan intervention, following the 7/4/11 fall, indicated the resident was to be referred to therapy. On 7/14/11 at at 6:55 a.m. Resident #C sustained a fourth fall. A change of condition report indicated Resident #C was found on the floor between the bed and the door. The report indicated the alarm did not sound and the resident had thrown the alarm across the room. The report noted no physical injuries. The interventions added to the fall risk care plan, following the 7/14/11 fall, indicated the alarm was put back in place. On 7/19/11 at 9:00 a.m., the Administrator was interviewed. He indicated Resident #C fell out of bed on 7/14/11 and the bed was not as low as it should have been at the time of the fall. The Administrator indicated the bed cord or plug had to be replaced so the bed could be adjusted to the lowest position. The policy for Falls Management, dated October 2010, provided by the Administrator, was reviewed on 7/19/11 at 1:30 p.m. and indicated, "...2. Initiate a fall prevention care plan when appropriate with strategies to			

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	155567	A. BUILDING 00 B. WING	07/19/2011

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	minimize falls and injuries. 3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries... 7. Evaluate actual or suspected causal factors for opportunities to prevent recurrences..." The policy included a page of clinical options and strategies for the management of fall risks. This Federal tag relates to Complaint Number IN00092713. 3.1-35(g)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interviews and record review, the facility failed to provide increased supervision when approaches failed to prevent falls. This deficiency affected 2 of 3 residents with multiple falls in a sample of 3. (Resident #B, and #C) Findings include: The closed clinical record of Resident #B was reviewed on 7/18/11 at 2:00 p.m. and indicated the resident was admitted to the facility from the hospital on 5/16/11, with	F0323	It is the policy of the facility to keep the resident environment as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. Resident B was discharged from facility on 6/21/11, unable to address. Resident C falls careplan was reviewed on 7/29/11 by IDT to ensure appropriate and progressive interventions have been put in place to minimize falls. Other residents with multiple falls in previous 3 months shall be reviewed by IDT to ensure appropriate	08/17/2011

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	diagnoses which included but were not limited to, dementia and CVA (Cerebral Vascular Accident). Resident #B was discharged to an assisted living facility on 6/21/11. The fall risk assessment, dated 5/16/11, indicated Resident #B was at high risk for falls. The fall risk care plan, dated 5/16/11, indicated Resident #B had fall risk factors, including; CVA, dementia, weakness and history of falls. The fall prevention interventions included: Provide adequate lighting Monitor side effects of meds (medications) Keep call light within reach Encourage use of call light Keep floors free of spills and clutter Monitor for unsteady gait and balance Labs as ordered Assess toileting needs Provide verbal safety cues Keep personal belongings within reach Keep assistive devices within easy reach (Wheel Chair) Wear clean & (and) clear eye wear Provide non-skid foot wear PT eval (physical therapy evaluation) and treat if indicated OT eval (occupational therapy evaluation) and treat if indicated		progressive interventions have been put in place to minimize falls. Licensed Nursing staff and IDT to be reeducated on facility's fall management program policy and procedure including selection of appropriate safety measures to meet the needs of the resident and updating the plan of care as necessary. DON or designee will review all falls and interventions to ensure that the most appropriate measures have been put in place to minimize the risk of falls for the resident. QA&A will monitor residents with multiple falls monthly to ensure the effectiveness of the staff utilization of the falls management program for a period of 6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	

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	Pressure sensor pad in bed (and) w/c (wheelchair) Low bed Physician orders, dated 5/16/11 and 5/17/11 respectively, indicated Resident #B was to have a PSA (Pressure Sensor Alarm) on the bed/ wheelchair at all times and was to receive Physical/Occupational Therapy five times per week for eight weeks. MDS (Minimum Data Set) Assessment, dated 5/23/11, indicated Resident #B required extensive assistance for transfer and toileting. The BIMS (Brief Interview of Mental Status) scores on the MDS assessments, dated 5/23/11, 5/26/11, and 6/7/11, indicated Resident #B had severe cognitive impairment. Resident #B sustained three unwitnessed falls on 5/19/11, 5/20/11 and 6/4/11; as follows: On 5/19/11 at 5:50 p.m., A fall investigation form indicated resident #B fell from her wheelchair. According to the report, a CNA heard the PSA (Pressure Sensor Alarm) sounding and found the resident on the floor sitting in front of her wheelchair. The Resident "was educated 0 (not) to lean forward to get objects out of reach, to			

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	use call light to ask for assistance..." The report indicated Resident #B complained of right hip pain, an x-ray of the right hip was ordered and neuro checks were initiated. On 5/20/11 at 8:00 a.m., Resident #B sustained a second fall. A change of condition report, dated 5/20/11, indicated Resident #B was observed sitting on the bathroom floor, the alarm had been removed, and the resident had attempted to self transfer to the toilet. The post-fall care plan indicated "encouraged use of call light for assistance." CNA #1, who discovered the resident on the floor, was interviewed on 7/19/11 at 12:00 noon, and indicated the resident's alarm was not sounding, when she discovered the resident on the bathroom floor. She indicated the resident had shut off her alarm. The right hip x-ray report, dated 5/20/11, noted an irregularity and bony fragment at the greater trochanter. Nursing notes, date 5/21/11 at 7:50 a.m., indicated physician orders were obtained to transfer the resident to the emergency room for evaluation of the right hip. The hospital emergency report, date			

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	5/21/11 at 1:12 p.m., indicated Resident #B was returned to the facility following an examination and a normal MRI (Magnetic Resonance Imaging) of the right hip. On 6/5/11 at 3:30 p.m., Resident #B sustained a third fall. The fall investigation report indicated the alarm was sounding and Resident #B was found on the floor next to her bed. According to the report, she had attempted to transfer from the wheelchair to the bed without assistance and missed the bed. The report indicated the "resident was reeducated on use of call light." The alarms, therapy and non-skid socks, previously care planned, were continued. The care plan indicated the only new fall prevention intervention attempted for the cognitively impaired resident, following the falls, was re-education and encouragement to use the call light. There was no documentation the use of the PSA alarm was reviewed or that the need for additional supervision was considered or planned. On 7/19/11 at 12:10 p.m., the administrator was interviewed regarding Resident #B's falls. He indicated re-education of a dementia resident was			

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	not an appropriate intervention. He indicated more "tangible" interventions should have been implemented to prevent her falls. 2. On 7/18/11 at 9:30 a.m., during the orientation tour, the ADON (Assistant Director of Nursing) indicated Resident #C had multiple falls. On 7/18/11 at 10:00 a.m., Resident #C was observed sitting in her wheelchair, in the therapy room, with an alarm attached to her clothing. On 7/18/11 at 1:30 p.m., she was observed resting in bed with an alarm attached to her clothing. The bed was in a low position. The clinical record of Resident #C was reviewed on 7/18/11 at 3:20 p.m., , and indicated the resident was re-admitted to the facility on 2/20/11 with diagnoses which included but were not limited to, left hip arthroplasty and Alzheimer's dementia. The MDS (Minimum Data Set) assessment, dated 4/21/11, indicated the resident required extensive assistance for transfer and toileting			

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	The most current fall risk assessment, dated 7/8/11, indicated the resident was at high risk for falls. The resident had four recent falls on 6/11/11, 6/25/11, 7/4/11 and 7/14/11, as follows: On 6/11/11 at 9:30 a.m., a fall investigation report indicated Resident #C was found on the activity room floor between the wheelchair and the couch. The report indicated Resident #C was found to have a purple discoloration on her lower back measuring 5 CM by 0.2 CM. Neuro checks were initiated for 72 hours The post-fall and the fall risk care plan indicated the interventions initiated, after the 6/11/11 fall, included; a pull tab alarm when up in wheelchair, assist to comfortable position in wheelchair, attempt to identify reasons for restlessness and address, increase frequency of activity program, and provide visual checks on a scheduled basis. After the neuro checks were completed, there was no documentation visual checks of Resident #C were provided on a scheduled basis.			

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	On 7/19/11 at 12:10 p.m., the Administrator was interviewed. The Administrator indicated, after the neuro checks, he could find no documentation visual checks were done on a scheduled basis. On 6/25/11 at 12:05 p.m., Resident #C sustained a second fall. A change of condition report indicated Resident #C was found on the living room floor between the wheelchair and couch, the alarm was sounding, the resident was assisted to bed, neuro checks were initiated for seventy two hours and a 3 cm by 2 cm discoloration was noted on her right knee. The interventions initiated on the fall risk and the post fall care plan, after the 6/25/11 fall, indicated hospice was to evaluate wheelchair positioning, and was to provide a low bed with floor mat. On 7/4/11 at 8:45 a.m. Resident #C sustained a third fall. A change of condition report indicated the alarm was sounding and Resident #C was found on the floor, after she attempted a self transfer from the wheelchair to the love seat in the activity room. The care plan intervention, following the 7/4/11 fall, indicated the resident was to			

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	be referred to therapy. On 7/14/11 at 6:55 a.m. Resident #C sustained a fourth fall. A change of condition report indicated Resident #C was found on the floor between the bed and the door. The report indicated the alarm did not sound and the resident had thrown the alarm across the room. The report noted no physical injuries. The interventions added to the fall risk care plan, following the 7/14/11 fall, indicated the alarm was put back in place. There was no documentation the effectiveness of the alarm, the response to the alarm or the positioning of the alarm had been reviewed. There was no documentation additional supervision of the resident was planned. On 7/19/11 at 9:00 a.m., the Administrator was interviewed. He indicated Resident #C fell out of bed on 7/14/11 and the bed was not as low as it should have been at the time of the fall. The Administrator indicated the bed cord or plug had to be replaced so the bed could be adjusted to the lowest position. The policy for Falls Management, dated October 2010, provided by the Administrator, was reviewed on 7/19/11			

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	at 1:30 p.m. and indicated, "...2. Initiate a fall prevention care plan when appropriate with strategies to minimize falls and injuries. 3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries... 7. Evaluate actual or suspected causal factors for opportunities to prevent recurrences..." The policy included a page of clinical options and strategies for the management of fall risks. This Federal tag relates to Complaint Number IN00092713. 3.1-45(a)(2)			